14202 N. 73rd Ave
Peoria, AZ 85381
623.399.6704
admin@buildingbeyond.co
www.buildingbeyond.co

Application Packet Date:_____

Participant Full Name:_____ DOB:_____ Grade:_____

Parent/Guardian Child RESIDES with:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Street Address:_____Apt:_____

City:_____ AZ Zip_____

Main Phone:_____ Text: Y N Alternate Phone:_____ Text: Y N

Parent/Guardian email:_____

Additonal Parent/Guardian Information: (If none, leave blank)

Name:_____ Relationship:_____

Street Address:_____Apt:_____

City:_____ AZ Zip_____

Main Phone:_____ Text: Y N Alternate Phone:_____ Text: Y N

Parent/Guardian email:_____

Emergency Contact Information (In addition to parent/guardians listed, please list two additional people that can pick up your child in an emergency)

Name:_____ Relationship:_____

Main Phone:_____ Alternate phone:_____

Name:_____ Relationship:_____

Main Phone:_____ Alternate phone:_____

Is there anyone who should not pick up your child?

Name:_____Reason:_____

Medical/Health Information

Physical Disabilities:_____

Health Issues/Diagnoses:_____

_____

If on the Autism Spectrum, which level? _____ASD1 _____ASD2 _____ASD3

Hearing Loss_____ If yes, please explain_____

Vision Loss_____ If yes, please explain_____

How does your child communicate?_____

Does your child receive: OT_____ PT_____ Speech_____

If yes, for what reasons?_____

Does your child receive Medicaid?_____ Does your child receive SSI?_____

Medications Taken at home (will not be dispensed on site):

_____

Behavioral Issues: _____

_____

Food Allergies:_____

_____

Health Insurance Name:_____ ID #:_____ Group #:_____

Primary Physician's Name:_____Phone Number:_____

Preferred Medical Facility:_____

Authorization for Emergency Medical Treatment

In the event emergency medical treatment is required due to illness or injury during the process of receiving services, or while being on the property of Building Beyond/C3, I authorize Building Beyond to:

Secure and retain medical treatment and transportation if needed.

Release participant records/information upon request to the authorized individual or agency involved in medical care

This authorization includes x-ray, surgery, hospitalization, medication and any procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached:

Content Signature:_____ Date:_____

Printed Name:_____Date:_____

Photo and Video Release

I give permission for Building Beyond personnel to take phots and any other audiovisual materials of me or my child for the promotional printed material, educational activities, social media and exhibitions or for any use for the benefit of Building Beyond.

_____I consent _____I DO NOT consent

Signature:_____ Date:_____

Printed Name:_____

Participant Name:_____

Behavioral Policy

We will treat all participants with dignity and respect.

I understand, that my child can be removed from this program for unacceptable behavior including fighting, inappropriate language, stealing, bullying, drugs, alcohol, weapons, or insubordination. This includes refusal to put away phone or inappropriate use of phone during instruction. Funds paid will not be returned if removed from the program.

Intervention techniques for behavioral issues will include, but not be limited to:

Friendly reminders, non-verbal reminders, active listening, reassurance, restating expectations, redirection, time away from group, parent/guardian contact.

Parent/Guardian Signature:_____Date:_____

Printed Name:_____

Goals you would like to see from this program:

_____

_____

_____

_____

Participant's Favorite Activities:

_____

_____

_____

Additional Information you feel would be helpful to us:

_____

_____

_____

_____